Stepping Stones ABA

4929 Darcy Woods Ln. Fuquay Varina NC 27526
Phone: 919-810-1459 Fax 919-400-4224
Rebecca@steppingstonesaba.com

INTAKE SCREENING FORM

Instructions:
Please complete and submit this screening form to schedule an appointment for an evaluation. You may submit this completed form to:

E-mail: rebecca@steppingstonesaba.com
Fax: 919-400-4224
***Or provide completed form to your BCBA/BCaBA**

A staff member will contact you to gather additional information and/or schedule an evaluation after you complete and submit the screening form.

You will need to bring the following additional information to the scheduled evaluation.

1. Your child's most recent IEP/BIP
2. Records of therapy (previous and current) for your child.
3. Diagnostic Information
4. Insurance Cards (if applicable)
5. Any documents related to services being received such as past intervention reports, or other relevant documents.

If you have any questions or need assistance, please call your 910-660-8200 or email info@centerforpbh.com.

Please answer to the best of your ability. If you do not know any answers, your Stepping Stones ABA Supervisor will work with you closely to determine if it is relevant information for treatment.

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BIOGRAPHICAL

Child's Name:_____Date of Birth: _____

Caregiver/Legal Guardian #1
Name:_____
Address:_____
City, State, Zip: _____
Sponsor Social: _____

Telephone:_____(Home) _____(Work)
_____ (Cell)

Caregiver/Legal Guardian #2
Name:_____
Address:_____
City, State, Zip: _____
Telephone:_____(Home)_____(Work)
_____ (Cell)

Who lives in the home?

_____

_____

CURRENT MEDICAL PROVIDERS AND SCHOOL INFORMATION

Name of Primary Care Physician: _____
Affiliation:_____
Address:_____
Telephone: _____

Name of Teacher: _____
School:_____
Address:_____
Telephone: _____

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PRIOR PROFESSIONAL CONTACTS

Please list all past and current therapies your child has received by completing each of the boxes below.

Service ☐ ☐	Start/ End Date (Month / Year)	How Often? ☐ ☐ ☐ ☐ _____	Length of each therapy session ☐ ☐ ☐ ☐ _____	What goals were being addressed?	Effect of therapy for feeding problem	Therapist Information (Name, address, telephone)
Occupational Therapy ☐ ☐ Yes No ☐ ☐		☐ 1x/ month ☐ 2x/ month ☐ ~~1x/week~~ ☐ 2x/ week ☐ 3x/ week	☐ 15 min ☐ 30 min ☐ ~~45 min~~ ☐ 1 hr ☐ 1.5 hrs		☐ Worse ☐ No change ☐ Improved	
Physical Therapy ☐ ☐ Yes No		☐ 1x/ ~~month~~ ☐ 2x/ month ☐ 1x/week ☐ 2x/ week ☐ ~~3x/~~ week	☐ 15 min ☐ ~~30 min~~ ☐ 45 min ☐ 1 hr ☐ 1.5 hrs ☐ _____		☐ Worse ☐ No change ☐ Improved	
Speech Yes No		☐ 1x/ month ☐ 2x/ month ☐ ~~1x/week~~ ☐ 2x/ week ☐ 3x/ week	☐ 15 min ☐ 30 min ☐ ~~45 min~~ ☐ 1 hr ☐ 1.5 hrs		☐ Worse ☐ No change ☐ Improved	
Early Intervention Yes No		☐ 1x/ month ☐ 2x/ month ☐ 1x/week ☐ 2x/ week ☐ 3x/ week	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs		☐ Worse ☐ No change ☐ Improved	
Others		☐ 1x/	☐ 15 min		☐ Worse	

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: (please list)		☐ month ☐ 2x/ month ☐ 1x/week ☐ 2x/ week ☐ 3x/ week	☐ 30 min ☐ 45 min ☐ 1 hr ☐ ☐ 1.5 hrs		☐ No change ☐ Improved	

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MEDICAL INFORMATION

Birth History

How many weeks pregnant were you when your child was born? _____
Was your child born by vaginal delivery or C-section? _____
What was your child's birth weight/length?_____lbs_____inches
Were there any problems at birth? _____
Were there any problems during pregnancy? _____

Medical History

Current Diagnoses: _____
At what age did your child receive each diagnosis: _____
Who provided the diagnosis: _____
Previous Illnesses: _____
Most recent hearing screen:_____; Results: _____
Most recent vision screen:_____; Results: _____
Past surgeries/hospitalizations: _____
History of any of the following? (Check all that apply):

☐ Seizures ☐ Diabetes ☐ Asthma ☐ Constipation
☐ (frequent) Vision problems ☐ Hearing Problems Sleep Problems

Describe all checked items above:

_____
_____

Current medications and dosages:

_____
_____

Allergies: Medications/Environmental/Seasonal: _____
Food Allergies: _____
Food Intolerance? (e.g. lactose intolerance): _____
Are immunizations up-to-date: _____
If not up-to-date, what is delinquent? _____
Any foods avoided intentionally by the family? _____
Does your child have any health-related restrictions regarding exercise?
Current height:___feet,____
inches Current weight:_____lbs.

DEVELOPMENTAL HISTORY

At what age did your child:

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Roll over: _____
Sit independently: _____
Take first steps: _____

Play games (like peek-a-boo):

Crawl:_____

Smile: _____
Babble:_____
Use single words: _____
Use short phrases: _____
Use sentences: _____
Toilet trained during day: _____
_____
Toilet trained at night: _____

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As an infant/toddler, was your child:

- ☐ Interested in people
- ☐ Overly active
- ☐ Easy to please
- ☐ Irritable/Cranky
- ☐ Difficult to nurse or feed
- ☐ Interested in toys
- ☐ Underactive
- ☐ Able to be flexible
- ☐ Difficult to soothe
- ☐ Resistant to touch
- ☐ Reactive to certain noises

SLEEP SCHEDULE

Check any that describe your child.

- ☐ Has difficulty going to sleep at night
- ☐ Tantrums when put to bed
- ☐ Has other behavior problems when put to bed
- ☐ Has difficulties going to sleep during naps
- ☐ Has difficulties staying asleep
- ☐ Has difficulties staying in bed
- ☐ Wants to sleep in caregiver's bed

My child goes to bed at_____pm.
My child wakes up at_____am.
My child takes a nap from_____to_____and_____to_____.

COMMUNICATION

What is your child's primary form of communication?

☐ Gestures ☐ Picture Exchange ☐ Sign Language ☐ Vocal Language ☐ Other_____

How does your child request items?

_____

Does your child… (Select Yes or No) Respond to his/her name? Yes No
Imitate words/sounds you say? Yes No Example_____
Imitate words/sounds from his/her favorite videos? Yes No Example_____
Label things that he/she sees? Yes No Example_____
Label things that he/she feels? Example_____
Label things that he/she smells? Example_____
Label things that he/she hears? Example_____
About how many different things can your child label? _____

Does your child… (Select Yes or No)
Follow one step directions? Example_____
Follow two or more step directions? Example_____

Respond to questions? Example_____
About how many questions can your child respond? _____
Tell you what happened during the day? Example_____
How many different words does your child say in a 30-minute period? _____

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ADAPTIVE SKILLS

Check one that best describes your child's mental abilities.

☐ Normal Intelligence ☐ Mild ID ☐ Moderate ID

☐ Severe ID ☐ Profound Intellectual Disability (ID)

Does your child… (Select Yes or No)

Feed self
Dress self
Help with household chores
Tie shoes
Walk up/down stairs
Stay near in public places
Imitate things you do
Talk to peers

Look you in the eye when you are talking
Makes eye contact when pointing
Point to things from 3 feet away or more
Play with toys the same way
Play with a limited number of toys
Play with toys appropriate (hit nails with hammer)
Play with toys imaginatively (use box as phone)
Plays with toys next to others

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Yes No	Yes No
Yes No	Yes No
Yes No	Yes No
Yes No	Yes No

OTHER BEHAVIOR PROBLEMS

Does your child have any other behaviors that you think are a problem? Check any one that describes your child's behavior.

Behavior	Occurs	Frequency
Temper tantrums	☐	____ times per hour day week month
Argues		____ times per hour day week month
Hurts self	☐	____ times per hour day week month
Hurts other people	☐	____ times per hour day week month
Complains of aches or pains	☐	____ times per hour day week month
Throws or breaks things	☐	____ times per hour day week month
Makes inappropriate sounds	☐	____ times per hour day week month
Attention Deficits		____ times per hour day week month
Phobias		____ times per hour day week month
Overactive for age	☐	____ times per hour day week month
Separation anxiety	☐	____ times per hour day week month
Doesn't pay attention		____ times per hour day week month
Stereotypy (hand-flapping)		____ times per hour day week month
Arm/Hand biting	☐	____ times per hour day week month

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Thumb sucking	☐	____ times per	hour	☐	day	☐	week	☐	month
Doesn't interact with people	☐	____ times per	hour	☐	day	☐	week	☐	month
Masturbation	☐ ☐	____ times per	hour	☐	day	☐	week	☐	month
Pica (eats inedible objects)		____ times per	hour	☐	day	☐	week	☐	month
Insists on routine	☐ ☐	____ times per	hour	☐	day	☐	week	☐	month
Other_____	☐ ☐	____ times per	hour	☐	day	☐	week	☐	month

What type of supervision does your child require?

☐ (Check one) Can be left unattended for brief periods
☐ of time
☐ Needs continuous monitoring, but can be accomplished in a group
Requires 1:1 supervision

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OTHER INFORMATION

If your child had an hour to do whatever he/she wanted. Please list which toys, activities, foods, or people he/she would play with:

Toys

1)
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____
8)_____
9)_____

Foods

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____
8)_____
9)_____

Activities

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____
8)_____
9)_____

People

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____
8)_____
9)_____

What are your top 3 goals for your child in the next 6 months, rank the priority of the goal, and describe what specifically needs to be addressed.

Priority:

1= not important, 2= somewhat not important, 3= Neutral, 4= somewhat important, 5= very important

Rank (1-3)	Skill	Priority	Describe
	Communication	1 2 3 4 5	
	Play Skills	1 2 3 4 5	

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	Social Skills		
	Problem Behavior		
	Functional Skills (toileting)		
	Other:_____		

Child Availability

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 am					
9:00 am					
10:00 am					
11:00 am					
12:00 pm					
1:00 pm					
2:00 pm					
3:00 pm					
4:00 pm					
5:00 pm					

Please indicate how interested you are in learning methods to teach your child new skills.

Not at all Interested	Somewhat Interested	Interested	Very Interested	Extremely Interested
☐		☐		

Please indicate how many hours each day you and your child are in the same room.

0-2 hours	2 to 4 hours	4 to 6 hours	6 to 8 hours	More than 8 hours
☐	☐	☐	☐	☐

Please indicate how many hours each day you practice new skills with your child.

0-2 hours	2 to 4 hours	4 to 6 hours	6 to 8 hours	More than 8 hours
☐	☐	☐	☐	☐